TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Jesse O. Schneringer, D.C.

**Respondent Name**
Texas Mutual Insurance Company

**MFDR Tracking Number**
M4-17-2221-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
March 22, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Billing for range of motion measurements was submitted 99456-W5-WP, $300 and was denied. I resubmitted a request for reconsideration and was denied a second time. Reimbursement should have been $300."

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor billed $300.00 for code 99456-W5-WP on line 3. Texas Mutual declined to pay paid [sic] this with message code 225."

**Response Submitted by:** Texas Mutual Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 13, 2016 | Designated Doctor Examination | $300.00 | $300.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

**Issues**

1. Are Texas Mutual Insurance Company's reasons for denial of payment supported?
2. Is Jesse O. Schneringer, D.C. entitled to additional reimbursement for the service in dispute?

**Findings**

1. Dr. Schneringer is seeking reimbursement for a designated doctor examination to determine impairment rating performed on December 13, 2016, represented by procedure code 99456-W5-WP. Texas Mutual Insurance Company (Texas Mutual) denied this service with claim administrative code 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION."

   Submitted documentation includes a Report of Medical Evaluation with an assigned impairment rating and a narrative report supporting that Dr. Schneringer performed an examination to determine the impairment rating, as required by 28 Texas Administrative Code §134.250. Texas Mutual's denial for this reason is not supported.

2. 28 Texas Administrative Code §134.250(4)(C) states that the following applies for billing and reimbursing an examination to determine impairment rating of a musculoskeletal body area:

   (ii) The MAR for musculoskeletal body areas shall be as follows:
   (I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area…

   The submitted documentation finds that Dr. Schneringer performed an examination to determine the impairment rating of the lumbar spine which included a physical evaluation with range of motion. Therefore the reimbursement for this service is $300.00. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | April 14, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.